next day BRIEFING

NHS Providers

# Draft Mental Health Bill 2022

On Monday 27 June the government published the draft Mental Health Bill (and explanatory notes), which will now undergo pre-legislative scrutiny. The Bill follows the 2021 white paper, Reforming the Mental Health Act, and Sir Simon Wessely's 2018 independent review of how to modernise the Mental Health Act 1983. This briefing summarises the key clauses in the draft Bill and sets out NHS Providers view on the key issues, as well as our press statement. For further information please contact Ella Fuller, NHS Providers senior policy advisor (ella.fuller@nhsproviders.org).

## Key points

- The draft Bill includes provisions that take forward a significant number of the proposals from the Reforming the Mental Health Act white paper including: the introduction of four new guiding principles, increasing the frequency of automatic referrals to the mental health tribunal, and the creation of the nominated person statutory role.
- The four new guiding principles are: choice and autonomy – ensuring service users' views and choices are respected; least restriction – ensuring the MHA powers are used in the least restrictive way; therapeutic benefit – ensuring patients are supported to get better, so they can be discharged from the MHA; and the person as an individual – ensuring patients are viewed and treated as individuals.
- There are a number of areas that the government consulted on that are not included in the draft Bill. These include: improving the interface between the Mental Health Act and the Mental Capacity Act; removing the associate hospital managers' panels; and the proposal that NHS bodies and local authorities should deliver on directions made by the mental health tribunal within five weeks. The government stated in its response to the consultation that it will consider these areas further given responses to the consultation from stakeholders. The government also committed to explore further its proposals regarding Advanced Choice Documents, advanced consent to admission, and Care and Treatment plans.
- The government estimates that ongoing costs for resourcing the reforms and upfront training costs for existing staff in healthcare and social care systems to total £436m for health care, £46m for the CQC and £446m for local authorities (present values, 2022/23 prices).
- When fully implemented, these reforms are estimated to cost an additional £100m per annum. The full implementation of these reforms is expected to take around ten years largely due to the lead-in time required to train additional clinical and judicial staff.

- At the moment, we understand the Bill will be introduced to parliament early next year at the earliest, following a period of pre-legislative scrutiny, and royal assent is expected later in 2023/24.

# Provisions of the draft Bill

## Autism and learning disability – clauses 1 and 2

### Summary

These clauses make provisions to limit the detention of people with a learning disability and/or autistic people under the Act where there is no co-occurring mental health condition. They also introduce duties on integrated care boards (ICBs) to improve understanding of risk of crisis amongst these groups of individuals and to improve the supply of community services to prevent inappropriate detentions. Further provisions include: placing care, education and treatment review meetings on a statutory footing; and new powers for the Secretary of State to make regulations specifying the format and content of risk registers, and pertaining to information-gathering by the ICB for the register and onward disclosure of this information.

### NHS Providers view

#### Clause 1: application of 1983 Act

We support the principle of the provisions changing how people with a learning disability or autism are treated under the Act. Changing the Act to make it clear someone with a learning disability or an autistic person will not be detained unless they also have a mental illness is a long overdue step.

A concern has been raised by some trusts that, by prohibiting detention beyond 28 days in Part 2 settings, but retaining the option of long-term detention in Part 3 settings (with these settings as defined in the Mental Health Act 1983), the proposed changes might have the unintended consequence of driving individuals into the criminal justice system. Trusts have concerns that these proposals presuppose that patients detained under Part 3 of the 1983 Act are inherently more risky than patients detained under Part 2, which is not necessarily the case.

More broadly, trusts are concerned at the creation of two very differently described Acts, depending on whether the patient has come into a service through a civil or forensic route. This is a particular concern given people with a learning disability and autistic people remain vulnerable wherever they are, but also if they have entered the criminal justice system as a consequence of inequalities in access to care and support at an earlier stage. The CQC found opportunities were missed early in the

lives of people with a learning disability and autistic people to prevent their admission to hospital and the 'system of care' for these groups of individuals is not fit for purpose.

Beyond this legislation, it will important to address the clear evidence of a historical inequity in the development, commissioning and provision of care and support for people with a learning disability and autistic people, which means that many individuals are not able to access the care and support that they need, from diagnosis and throughout their lives, in a timely way. Historical under-investment in the NHS' core capacity to deliver services for people with a learning disability and autistic people, exacerbated by a sustained period of cuts to local authority support, is a key issue to address. Further significant challenges impacting trusts' ability to consistently provide the right level and nature of support for these groups of individuals include: increasing demand, disjointed and fragmented approaches to commissioning, workforce shortages – particularly of specialist staff, and constrained funding for high-quality services in the community and social care.

### Clause 2: people with autism or learning disability

We welcome the introduction of a duty on ICBs to establish and maintain a register of people usually resident in its area who the ICB considers to be autistic or have a learning disability and who are at risk of detention under Part 2 of the 1983 Act. Trusts would welcome clarity on how the government envisages local registers being resourced, supported and monitored.

We welcome the provision that ICBs and local authorities must have regard to the information on the register that covers their area when fulfilling their commissioning functions. We have previously emphasised the need for local systems to keep a sharp focus on the need to invest and strengthen community services for people with a learning disability and autistic people and disinvest in inappropriate and poor-quality care.

This provision needs to be backed by substantial, sustained levels of investment, especially for social care, given the current lack of robust community providers and specialist staff to deliver such services. Funding mechanisms also need to be improved and made more transparent, and we welcome provisions in the Health and Care Act 2022 requiring the government to set out its expectations for levels of mental health expenditure by NHS England and ICBs. Greater transparency would help to guarantee that funding for the sector reaches the frontline services that people with a learning disability and autistic people rely on and need most, and is invested in establishing the full range of high-quality services these groups of individuals need to live as independently as possible. Prioritising the NHS long term plan's ambition to give people a personal health budget where possible, with the

appropriate governance and safeguards, is also important so that funding truly follows service users and they can get the tailored and bespoke packages of care required.

More fundamentally, immediate action needs to be taken nationally and locally to tackle the stigma associated with learning disabilities and autism, and raise awareness of the need to improve the accessibility and quality of care and support for these groups of individuals. This is vital to ensuring appropriate support and priority is given to the full range of services people rely on, at levels which reflect the significant structural inequities these groups of individuals and services have suffered historically. A key part of improving accessibility and the quality of the care and support people receive is through the delivery of reasonable adjustments in mainstream inpatient settings, when they are appropriate, which is already a national requirement.

Discussions and decision making regarding the best approach to delivering high-quality, person-centred care in highly specialist and forensic settings also needs to be more balanced and evidence-based, taking into better account the nature of the care and support provided by these services and the geographic spread of their service user populations. This would better mirror the approach taken for specialist physical health services.

## Grounds for detention and community treatment orders – clauses 3 to 5

### Summary

These clauses include a provision for two new tests that must be met to fulfil the criteria for detention and community treatment orders: firstly that "serious harm may be caused to the health or safety of the patient or of another person" and secondly that the decision maker must consider "the nature, degree and likelihood of the harm, and how soon it would occur". The purpose of these changes is to provide greater clarity as to the level of risk of harm that a person must present in order to be detained. These clauses also make the provision for reviews and appeals of both detentions and treatment to be provided at an earlier stage and more frequently.

### NHS Providers view

#### Clause 3: Grounds for detention

We welcome the principle behind the provisions reforming the detention criteria to ensure people in all areas of the country are detained only when and for as long as necessary. There are particular issues that trusts have highlighted they would welcome clarity on. This includes a better understanding of who would undertake the proposed assessment on what setting provides the most therapeutic package of care, when there are decisions to be made about when and whether to

discharge a patient. It would also be helpful to understand how the government is envisaging introducing more checks on whether a patient's detention continues to be appropriate.

Trusts have also raised particular concerns that, as forensic services provide care for people under Part II and Part III of the 1983 Act, they will be required to operate under two different criteria for detention. They are also concerned that the proposed changes to the detention criteria risk people who are a significant risk to themselves or others needing to be more acutely unwell than their civil counterparts in order to access the care and treatment they require.

In supporting patients who will not meet the criteria for detention under a reformed Act and when using least restrictive approaches, trusts have highlighted that there will be a particular need for improved collaborative working with community partners and multi specialist agencies. This will help to ensure referral pathways back into community providers and safety plans are clear, robust and effective.

Furthermore, while the provisions for more stringent criteria may help reduce detention rates, we also need to address the underlying issues driving the pressures on services and the rising severity and complexity of people's needs at the point at which they present to services fundamentally.

### Clause 4: Grounds for community treatment orders (CTOs)

We welcome the provision to revise the criteria for the use of CTOs and enhance the professional oversight required for any CTO. Trusts have previously told us that the scope of mandatory restrictions under CTOs are complex and CTOs are ineffective at preventing readmissions. It will be important that the government – as it earlier committed to doing – monitors the effects of the changes, particularly the impact of increasing evidence requirements.

### Clause 5: Grounds for discharge by tribunal

The provisions in this clause set out that a mental health tribunal must discharge a patient where the patient no longer satisfies the revised detention criteria relevant to their detention. The new discharge criteria will apply automatically to unrestricted Part 3 patients, who are discharged under section 72(1)(b) of the 1983 Act, and to restricted patients, who are discharged under section 73, by virtue of clause 5(3) and (4) of this draft Bill.

There will be a particular need for the right level of resources and improved collaborative working with community partners and multi specialist agencies to support patients who are discharged as they

no longer satisfy the revised detention criteria relevant to their detention. This will help to ensure referral pathways back into community providers and safety plans are clear, robust and effective.

We support provisions that increase individuals' access to a mental health tribunal. However, the impact of these provisions on trusts' resources and workload needs to be fully assessed. Some trusts have told us the changes may require staff to spend more time writing reports and attending tribunals, and risk negatively affecting patient care if not accompanied by a commensurate increase in staffing levels.

## Appropriate medical treatment – clauses 6 and 7

### Summary

These clauses include a new requirement that, when considering whether medical treatment under the Act is "appropriate" for a patient, consideration must be given to whether there is a reasonable prospect that the outcome of the treatment would have a therapeutic benefit. A new definition of "appropriate medical treatment" is also set out: the treatment must have a reasonable prospect of alleviating, or preventing the worsening of, the patient's mental disorder or one or more of its symptoms or manifestations, to ensure that therapeutic benefit is considered both in relation to the purpose and likely outcome of the treatment. There is also a new provision that allows the remission of, or the release of where relevant, prisoners and detainees back to their place of detention when no effective treatment for the mental disorder can be given.

### NHS Providers view

#### Clause 6: Appropriate medical treatment: therapeutic benefit

Trusts have told us that the criteria of "therapeutic benefit" requires further clarification to fully understand the implications of these changes in practice, and to ensure they are interpreted by all parties consistently. It will also be important to clarify whether interventions that meet the needs of certain patients, such as habilitation and milieu therapy for people with a personality disorder, could be excluded from the scope of the Act under the new "therapeutic benefit" criteria.

## Treatment – clauses 9 to 18

### Summary

These clauses add statutory weight to patients' rights to be involved in planning their care, and to make choices and refusals regarding the treatment they receive. They include provisions to make care and treatment plans statutory, as well as introduce a new framework for patient consent and refusal

of medical treatment. Further provisions include: bringing forward the point at which the second opinion appointed doctor (SOAD) reviews a patient's treatment; making the SOAD responsible for assessing if the patient's compulsory treatment has a therapeutic benefit and that the new duty on clinicians to consider a number of matters has been applied; and the ability for patients to appeal treatment decisions at the tribunal if evidence suggests wishes and preferences were inappropriately overruled.

## NHS Providers view

### Clause 9: Making treatment decisions

This introduces a duty on the clinician in charge of the patient's treatment to consider certain matters and take a number of steps when deciding whether to give treatment under Part IV of the Act. We agree that the Act must hold the individual service user's human rights, dignity and legal protections as the highest priority. More effort must also be made to ensure that service users and, where appropriate, their families are active participants in the treatment and care planning for their recovery at the earliest opportunity. It will be important to ensure health and care staff have sufficient capacity to deliver this provision as intended in practice.

### Clause 11: Medicine etc: treatment conflicting with a decision by or on behalf of a patient
### Clause 15: Urgent treatment to alleviate serious suffering

Clause 11 introduces new safeguards for patients who are refusing treatment at the time or where treatment is in conflict with a decision made by a donee or deputy or the Court of Protection. Clause 15 removes the power to administer urgent treatment to patients on the basis that it is considered immediately necessary to alleviate serious suffering by the patient. A number of trusts have indicated their support for respecting the right of patients with capacity to refuse treatment if they wish, even if the treatment is considered immediately necessary to alleviate serious suffering. However, others have stated their preference for considering cases where this issue might arise on an individual basis. One trust told us they felt there is a contradiction between the 'therapeutic benefit' guiding principle and the right to refuse treatment, as well as cautioning that refusing some treatments may lead to patients staying in hospital for longer and receiving suboptimal care. These changes need to be supported by clear guidance.

### Clause 17: Capacity to consent to treatment

Clause 17 amends current wording in the 1983 Act, moving from reference to whether the patient is "capable of understanding the nature, purpose and likely effects" of that treatment, to reference to "capacity or competence to consent". This amendment is not expected to create a practical change in

clinical approaches to assessing capacity or competence. Trusts had fed back to us previously that frontline professionals need greater clarity as to what constitutes appropriate consent to treatment.

### Clause 18: Care and treatment plans

Where appropriate, clinicians will be required to prepare and regularly review a personalised care and treatment plan for certain patients detained under the MHA. This should set out how the patient's current and future needs, arising from or related to their mental disorder, will be met. We support changed to the 1983 Act that enable service users to have a more active role in their care planning with a focus on recovery. We have said previously that more effort must be made to ensure that service users and, where appropriate, their families are active participants in the treatment and care planning for their recovery at the earliest opportunity, and making care and treatment plans statutory should help with this. It will be important to ensure health and care staff have sufficient capacity to deliver this provision as intended in practice.

## Community treatment orders – clauses 19 and 20

### Summary

These clauses strengthen the criteria and increase evidence requirements for CTOs, so that they are only used where there is strong justification for doing so and where the CTO is considered to deliver a genuine therapeutic benefit to the patient. Particular provisions include: requiring a community clinician to be involved in decisions regarding the use and operation of CTOs; and imposing specific duties on community clinicians where they are not the responsible clinician.

### NHS Providers view

### Clause 19: Consultation of the community clinician

### Clause 20: Conditions of community treatment orders

We welcome these provisions in principle. Trusts have previously told us that the scope of mandatory restrictions under CTOs are complex and CTOs are ineffective at preventing readmissions. It will be important to monitor the effects of changes, particularly the impact of increasing the involvement of community clinicians and evidence requirements.

## Nominated persons – clauses 21 to 25

### Summary

These clauses introduce a new statutory role – the nominated person – to replace the nearest relative currently referred to in the 1983 Act. This will enable service users to select who represents them

and exercises the relevant statutory functions from the draft Bill on their behalf. The Department of Health and Social Care will continue to explore the rights for those under Part III of the Act alongside the Ministry of Justice and other partners in the justice system. Additional support and guidance will be provided for those involved in a patient's care, including clarity on how these new powers interact with existing legal rights.

### NHS Providers view

**Clause 21: Nominated person**
**Clause 22: Applications for admission or guardianship: role of nominated person**
**Clause 23: Discharge of patients: role of nominated person**
**Clause 24: Community treatment orders: role of nominated person**
**Clause 25: Transfer of patients: role of nominated person**

We support updating the nearest relative provisions and, on the whole, the proposed additional powers of the nominated person. Some trusts have told us they anticipate that the mental health tribunal will have a key role to play in making further determinations if a person's choice is potentially inappropriate or harmful. Trusts have also highlighted it will be important to work through who determines what the patient's best interests are if the nominated person is objecting to a CTO, and other practical issues, such as how and when people can change their mind regarding who their nominated person is and who should keep track of this. There may also be the risk that legislating so that the nominated person's objection to admission can be temporarily overruled, as opposed to them being removed or displaced, might give rise to a need for serial proceedings to overrule every single decision.

## Detention periods – clause 26

### Summary

These clauses include a provision that shortens the period that a patient may be kept in detention for treatment, and if the patient's detention is to continue it must be reviewed and renewed more frequently. In the draft Bill, a patient may not be kept in detention for treatment for longer than three months without the authority for the patient's detention being renewed. There is also an amendment in the draft Bill to shorten the subsequent detention period from six months to three months.

### NHS Providers view

**Clause 26: Detention periods**

We welcome the aspirations behind the provisions to ensure people in are detained for shorter periods of time, and only when absolutely necessary. It will be important to fully assess the impact of more frequent reviews and renewals on trusts' resources and staff workload.

## Periods for applications and references – clauses 27 to 29

### Summary

The draft Bill proposes amendments to extend the period in which a patient may apply to mental health tribunals and extend the existing referral system to increase the frequency and widen the group of patients automatically referred to the tribunal. There is also an amendment made to the 1983 Act so that automatic referrals immediately follow the expiry of the period in which a patient could make an application to the tribunal.

### NHS Providers view

#### Clause 27: Periods for tribunal applications

#### Clause 28: References to tribunal

Trusts support proposals to increase an individual's access to the tribunal and we therefore welcome extending the periods for tribunal applications, and amending the Act so that automatic referrals immediately follow the expiry of the period in which a patient could make an application.

However, the impact of these proposals on trusts' resources and workload need to be fully assessed. Some have told us the changes may require staff to spend more time writing reports and attending tribunals, and risk negatively affecting patient care if it is not accompanied by a commensurate increase in staffing levels. Trusts may also need to ensure physical space is available to accommodate an increased number of meetings. There may also be resource issues for the first tier tribunal, though it has been recognised that the greater use of videoconferencing prompted by the pandemic may provide an opportunity to reduce costs. Trusts welcome the proposals to reduce paperwork and bureaucracy, and have told us the introduction of report templates that can be amended would be particularly beneficial.

Trusts support there no longer being an automatic referral to a tribunal for CTO revocation, though the importance of making special provisions to ensure people in specific circumstances do not fall through the net is also a concern.

#### Clause 29: References to tribunal for patients concerned in criminal proceedings etc

This clause includes a provision to reduce the automatic referral period for Part III restricted patients from three years to 12 months. It also provides an additional safeguard to ensure that no conditionally discharged patient can be detained for a period of more than four years without their detention being reviewed by the mental health tribunal. Trusts had previously told us that the inequitable arrangements for patients in the criminal justice system compared with others assessed under the 1983 Act is a key issue. Trusts also expressed support for equivalence of care for restricted patients and those in the community; shortening timescales from assessment to hospital admission; and making return to custody easier.

## Patients concerned in criminal proceedings or under sentence – clauses 30 to 33

### Summary

These clauses include a provision to introduce a new 28-day time-limit for transfers from prison to hospital for prisoners with severe mental health needs to improve timely access to specialist inpatient care and treatment and a new form of supervised community detention for patients convicted of crimes who are ready for discharge from hospital, but who require a continuing deprivation of their liberty in the community. The nominated person will also have limited powers in this context, and tribunal powers and automatic referrals to the tribunal will differ also for these patients compared to civil patients.

### NHS Providers view

**Clause 30: Conditional discharge subject to deprivation of liberty conditions**

**Clause 31: Transfers from prison to hospital**

Trusts expressed concern that the 28-day limit on transfers from prison or immigration removal centres to a secure hospital depends on the number of patient beds available, as well as means of transport and the location of a secure hospital. We welcome that the government has previously acknowledged these concerns, and clarified that, although it will introduce this legislative change, it will only commence once NHS England guidance on transfer and remissions has been fully embedded. We need to ensure there is enough fit for purpose capacity to provide care and treatment according to legislative requirements in an inpatient setting for people in the criminal justice system who require it.

## Help and information for patients – clause 34 to 37

### Summary

These clauses include provisions to expand the right to access the services provided by an independent mental health advocate (IMHA) to voluntary patients in England who are not detained under the MHA. The measures will also ensure that all qualifying patients (both compulsory and voluntary patients) will be offered services through automatic referral to an IMHA provider. There are also amendments to the 1983 Act to seek to ensure decisions are made in the context of each person's individual needs. Further provisions include a series of statutory duties on hospital managers to supply information about complaints to patients and the nomination person.

### NHS Providers view

#### Clause 34: Independent mental health advocates

Trusts have told us that the proposal to expand the role of IMHAs is positive, although they also note that it will require investment and additional training, with particular resource implications for local authorities given current commissioning arrangements. Drawing a clear distinction between IMHAs and the role of the legal representative has also been raised by trusts as important.

More broadly, trusts have emphasised the value of advocacy services and their concern at the level of variation in service provision and advocacy support at the moment, depending on where a patient lives. Enhancing standards, regulation and/or accreditation could help to improve services, many trusts have told us that the focus should be on increasing resources for advocacy services first and foremost.

## After-care – clauses 38 and 39

### Summary

Clause 38 extends the mental health tribunal's power to make recommendations to local commissioners to make plans for the provision of after-care services for patients to facilitate a patient's discharge at a future date. The power for the tribunal to reconvene to consider a patient's case again if the recommendations have not been complied with will also apply to this new power.

Clause 39 amends section 117 after-care to last until the NHS body and the local authority jointly give notice to the person that they are satisfied that the person is no longer in need of such services. This clause also makes reforms to the identification of which particular NHS body and local authority is responsible for arranging section 117 aftercare to an individual patient.

## Miscellaneous – clauses 40 to 44

### Summary

This section includes a clause (clause 41) concerning the removal of police stations and prisons as places of safety. A subsection of the draft Bill clarifies that these changes do not apply to those already detained in a police station or prison when the changes commence.

### NHS Providers view

**Clause 41: Removal of police stations and prisons as places of safety**

We have welcomed that the government has said previously it will ensure that the necessary adaptations and investment are in place before legislative changes are commenced as a final step to delivering the objective of removing police stations as a designated place of safety. It is important that this promised investment is targeted at increasing resources and capital funding for trusts to the level they will require to be able meet the demand in hospital emergency departments and other health-based places of safety that is likely to result from this change.

## General – clauses 45 to 49

### Summary

These clauses set out the intended commencement of the eventual Act and make provision for consequential changes.

## Schedules

### Summary

The three schedules cover arrangements relating to the application of the 1983 Act to autism and learning disability; nominated persons (including their appointment, functions and functions where patients are concerned in criminal proceedings; and independent mental health advocates for informal patients.

# Financial implications

An impact assessment has been prepared for the draft Bill which outlines the cost implications for bodies and organisations which derive from its proposed measures in England over a 14-year appraisal period.

In healthcare and social care systems, ongoing costs for resourcing the reforms and upfront training costs for existing staff are estimated in the central scenario to total £436m for health care, £46m for the CQC and £446m for local authorities (present values, 2022/23 prices).

The increased frequency of referrals to the mental health tribunal creates costs for Her Majesty's Courts and Tribunals Service (HMCTS) and the Legal Aid Agency, estimated at a total of £171m (present value, 2022/23 prices) in the central scenario.

When fully implemented, these reforms are estimated to cost an additional £100m per annum. The full implementation of these reforms is expected to take around ten years largely due to the lead-in time required to train additional clinical and judicial staff.

## Further resources

- Next day briefing on the government's Reforming the Mental Health Act white paper
- NHS Providers consultation response to the white paper
- Next day briefing on government's response to the white paper consultation

## NHS Providers media statement

Commenting on the government's announcement of better mental health support, Saffron Cordery, interim chief executive of NHS Providers said:

"NHS leaders – from mental health trusts and beyond – welcome the publication of the draft bill on Mental Health Act reform. It's been a long time coming and is an important opportunity to implement reforms that will give service users greater autonomy and improve the quality of their treatment and care.

"The focus on tackling the injustices of race inequality in mental health practices and better meeting the needs of those with a learning disability and autistic people are particularly welcome.

"However we should be under no illusions that while the additional funding to support implementation is useful, mental health services are significantly understaffed and in desperate need of capital investment to shore up outdated buildings and infrastructures.

"Without a fully costed and funded long term workforce plan and without significant changes to the

capital regime, NHS mental health services won't overcome the substantial shortfall in care for those who need it most – some of the most vulnerable people in our society."

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